No. 665

In the Supreme Court of the United States

OCTOBER TERM, 1941

HARRIET V. PENCE, PETITIONER

v.

THE UNITED STATES OF AMERICA

ON WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES

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OPINIONS BELOW

The opinion of the District Court on motions after verdict (R. 219–222), and its supplemental opinion (R. 223), are not reported. The majority and dissenting opinions in the Circuit Court of Appeals (R. 246–253) are reported in 121 F. 2d 804.

JURISDICTION

The judgment of the Circuit Court of Appeals was entered on July 2, 1941 (R. 254), and a petition for rehearing was denied on August 4, 1941 (R. 254). The petition for a writ of certiorari was filed on September 29, 1941, and was granted

on November 10, 1941 (R. 256). The jurisdiction of this Court is conferred by Section 240 (a) of the Judicial Code, as amended by the Act of February 13, 1925.

QUESTIONS PRESENTED

1. Whether, as a matter of law, the evidence requires a finding that the policy sued on was obtained by fraud.[1]

2. Whether the Circuit Court of Appeals had jurisdiction to hear and determine the appeal on its merits despite the omission from the original record on appeal of a statement of points, required by a rule of the Circuit Court of Appeals, when the required statement was later embodied in the record by permission of that court.

PERTINENT RULES AND REGULATIONS

Rule 9 of the Circuit Court of Appeals for the Seventh Circuit provides in part as follows:

> 1. Where an appeal is taken to this court, the appellant shall file with the clerk of the district court, for inclusion in the record on appeal, a statement of points which shall

[1] Petitioner contends (Pet. 21–24, Br. 8–10) that the holding of the Circuit Court of Appeals, that fraud was established as a matter of law, leaving no question of fact for submission to the jury, contravenes the Seventh Amendment to the Constitution and Rule 50 (b) of the Federal Rules of Civil Procedure. The contention, however, is based upon the substantive proposition that fraud was not established as a matter of law and in effect raises only the question set out above.

set out separately and particularly each error asserted and intended to be urged. No appeal shall be considered unless such a statement of points shall have been so filed.

Rule 73 of the Rules of Civil Procedure for the District Courts provides:

RULE 73. APPEAL TO A CIRCUIT COURT OF APPEALS.

(a) HOW TAKEN.—When an appeal is permitted by law from a district court to a circuit court of appeals and within the time prescribed, a party may appeal from a judgment by filing with the district court a notice of appeal. Failure of the appellant to take any of the further steps to secure the review of the judgment appealed from does not affect the validity of the appeal, but is ground only for such remedies as are specified in this rule or, when no remedy is specified, for such action as the appellate court deems appropriate, which may include dismissal of the appeal.

* * * * *

(g) DOCKETING AND RECORD ON APPEAL.—The record on appeal as provided for in Rules 75 and 76 shall be filed with the appellate court and the action there docketed within 40 days from the date of the notice of appeal; except that, when more than one appeal is taken from the same judgment to the same appellate court, the district court may prescribe the time for filing and docketing, which in no event shall be less than 40 days

from the date of the first notice of appeal. In all cases the district court in its discretion and with or without motion or notice may extend the time for filing the record on appeal and docketing the action, if its order for extension is made before the expiration of the period for filing and docketing as originally prescribed or as extended by a previous order; but the district court shall not extend the time to a day more than 90 days from the date of the first notice of appeal.

Rule 75 of the Rules of Civil Procedure for the District Courts provides:

RULE 75. RECORD ON APPEAL TO A CIRCUIT COURT OF APPEALS.

* * * * *

(d) STATEMENT OF POINTS.—If the appellant does not designate for inclusion the complete record and all the proceedings and evidence in the action, he shall serve with his designation a concise statement of the points on which he intends to rely on the appeal.

* * * * *

(h) POWER OF COURT TO CORRECT RECORD.—It is not necessary for the record on appeal to be approved by the district court or judge thereof, but, if any difference arises as to whether the record truly discloses what occurred in the district court, the difference shall be submitted to and settled by that court and the record made to conform to the truth. If anything material to either party

is omitted from the record on appeal by error or accident or is misstated therein, the parties by stipulation, or the district court, either before or after the record is transmitted to the appellate court, or the appellate court, on a proper suggestion or of its own initiative, may direct that the omission or misstatement shall be corrected, and if necessary that a supplemental record shall be certified and transmitted by the clerk of the district court.

Veterans' Bureau Regulation No. 14 (Regulations and Procedure, p. 83) provides:

> 9. *Application and proof of insurability.*—The applicant for reinstatement or reinstatement and conversion must furnish during his lifetime a written application signed by him, which shall state that he is in as good health as at date of lapse, or that he is in good health, and that he is not permanently and totally disabled in accordance with the requirements of the particular case, and in addition the applicant shall furnish such evidence relative to his physical condition as may be required by the director, and on such forms as the director may prescribe: * * *.

STATEMENT

The petitioner, widow and beneficiary of the insured (R. 2, 3), brought suit on a contract of United States Government life (converted) insurance issued to Lawrence W. Pence on July 1, 1927 (R. 1–5).

The insured, an eye, ear, nose and throat specialist (R. 177, 212), was a medical officer in the military service of the United States from August 7, 1918, to January 9, 1919; during that period he obtained a $10,000 contract of yearly renewable term insurance which on March 2, 1920, lapsed for nonpayment of the premium due February 1, 1920 (R. 2, 14, 197). The policy now sued on is the renewal (R. 174–175) of a policy issued upon applications, executed on June 21, 1927, for reinstatement and simultaneous conversion of the lapsed term policy (R. 169–174, 206–207).[2] Premiums on this reinstated and converted insurance were tendered and accepted from the date of its issuance in 1927 through the month of August 1934. The insured died on September 21, 1934, during the grace period of 31 days allowed for payment of the premium for September 1934 (R. 14–15).

The only issue presented in the District Court was raised by the Government's affirmative defense that the policy was obtained by fraudulent representations on the part of the insured in his application for reinstatement (R. 10).[3]

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[2] The reinstatement was obtained under Regulation No. 14, *supra*, p. 5, requiring, *inter alia*, that the applicant submit "such evidence relative to his physical condition as may be required by the director, and on such forms as the director may prescribe * * *."

[3] The policy sued on was contestable at any time on the ground of fraud. See Section 307, World War Veterans' Act (38 U. S. C. 518), which makes the policy incontestable from the date of its issuance except for specific grounds, including fraud.

The Government's motion for a directed verdict, made after all the evidence had been introduced (R. 157), and its motion for judgment, made after the verdict was returned, upon the ground that the evidence required a finding in its favor (R. 215–217), were denied (R. 223).

Judgment on a verdict in petitioner's favor (R. 218) was entered on May 28, 1940 (R. 225–226). Notice of appeal was filed by the Government on August 26, 1940 (R. 227), and the record was filed in the Circuit Court of Appeals on November 23, 1940,[1] within the time allowed by an order of the District Court entered on September 30, 1940 (R. 227–228).

On February 15, 1941, petitioner moved in the Circuit Court of Appeals to dismiss the appeal or to affirm the judgment on the ground, *inter alia*, that the record did not include a statement of points, as required by Rule 9 of that court (R. 239–240). Pursuant to leave granted by the Circuit Court of Appeals on February 26, 1941 (R. 245, 247), the statement of points was filed in the District Court on February 28, 1941 (R. 233–234), and in the Circuit Court of Appeals on March 3, 1941 (R. 245). The Circuit Court of Appeals held petitioner's motion to be without merit and denied it (R. 245, 247).

The Circuit Court of Appeals further held, one judge dissenting, that the evidence on the issue of

[1] The date of filing appears from the cover of the transcript of record in the Circuit Court of Appeals.

fraud required a finding in favor of the Government as a matter of law and, accordingly, that the District Court erred in denying the Government's motion for a directed verdict (R. 246–253). The judgment was reversed and the case remanded to the District Court for further proceedings in harmony with the holding of the Circuit Court of Appeals (R. 253, 254).

SUMMARY OF ARGUMENT

1. The evidence, recited in detail in the Argument, establishes beyond contradiction that one or more of the material representations made by the insured in his application for reinstatement was false, that each of the representations was made by the insured with knowledge of its falsity and with intent to deceive, and that the Government relied upon each of them in reinstating the policy. Since all of the elements of fraud were thus established by uncontradicted evidence, the Circuit Court of Appeals properly held that a verdict should have been directed for the Government. The portions of the record upon which petitioner relies do not create a conflict of evidence justifying submission of the issue of fraud to the jury.

2. The Circuit Court of Appeals properly denied petitioner's contention that it lacked jurisdiction to hear the appeal because a statement of points had not been included in the original record transmitted to it, as required by Rule 9 of

the Rules of that court. The requirements of Rule 9, as the court below held, are not jurisdictional in nature.

ARGUMENT

I

THE CIRCUIT COURT OF APPEALS PROPERLY HELD THAT A VERDICT SHOULD HAVE BEEN DIRECTED FOR THE GOVERNMENT

The court below held that the evidence in this case establishes beyond contradiction that the insured had made misrepresentations in his application, signed by him on June 21, 1927 (R. 169–172), for reinstatement of his insurance which had lapsed on March 2, 1920 (R. 14), that these misrepresentations were fraudulent,[5] and accordingly that the District Court should have

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[5] The elements of the defense of fraud in such a case as the present one are disclosed in numerous decisions to be these: (1) A false representation (2) in reference to a material fact (3) made with knowledge of its falsity (4) and with the intent to deceive and be acted upon (5) when action has been taken in reliance upon the representation. *Mutual Life Insurance Co.* v. *Hilton-Green*, 241 U. S. 613, 620, 622; *Claflin* v. *Commonwealth Ins. Co.*, 110 U. S. 81, 95; *New York Life Ins. Co.* v. *Fletcher*, 117 U. S. 519, 533; *Cooper* v. *Schlesinger*, 111 U. S. 148 (finding no error, p. 155, in the instructions of the District Court to the jury, pp. 152–153); *Lehigh Zinc and Iron Co.* v. *Bamford*, 150 U. S. 665, 673; *United States* v. *Depew*, 100 F. (2d) 725 (C. C. A. 10); *Hindman* v. *First National Bank*, 112 Fed. 931, 944–945 (C. C. A. 6). Cf. *Southern Development Co.* v. *Silva*, 125 U. S. 247, 250; *Derry* v. *Peek*, 14 App. Cas. 337, 374 (House of Lords).

directed a verdict in favor of the Government.* This decision we believe to be plainly correct.

The fraudulent representations were contained in the answers given to the following questions in the application for reinstatement:

> 7. Have you been ill, or contracted any disease, or suffered any injury, or been prevented by reason of ill health from attending your usual occupation, or consulted a physician in regard to your health, since lapse of this insurance? (Answer "Yes" or "No".) *No.* If so, give dates and full particulars, including the name and address of physician----------
> ----------
> ----------
>
> 11. Have you ever been treated for any disease of brain or nerves *No,* throat or lungs *No,* heart or blood vessels *No,* stomach,

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*The rule is well settled that "When, on the trial of the issues of fact in an action at law before a Federal court and a jury, the evidence, with all the inferences that justifiably could be drawn from it, does not constitute a sufficient basis for a verdict for the plaintiff or the defendant, as the case may be, so that such a verdict, if returned, would have to be set aside, the court may and should direct a verdict for the other party." *Slocum* v. *New York Life Insurance Co.*, 228 U. S. 364, 369, quoted in *Gunning* v. *Cooley*, 281 U. S. 90, 93, with numerous supporting decisions of this Court. "A mere scintilla of evidence is not enough to require the submission of an issue to the jury." *Gunning* v. *Cooley*, p. 94; *Penna. R. Co.* v. *Chamberlain*, 288 U. S. 333, 339; cf. *Consolidated Edison Co.* v. *National Labor Relations Board*, 305 U. S. 197, 229.

liver, intestines *No,* kidney or bladder *No,* genito urinary organs *No,* skin *No,* glands *No,* ear or eye *No,* bones *No.* (Answer each "Yes" or "No". If "Yes" describe fully and give dates.) _____
_____
_____
(R. 169, 171–172; answers put in italics).[1]

The evidence establishes that the negative answer given to question 7 was untrue in three respects: first, because the insured had consulted a physician in regard to his health since the lapse of the insurance; second, because he had been ill between the date of the lapse of the policy and the date of the reinstatement application; and, third, because he had been prevented from attending his usual occupation by reason of ill health during the policy's lapse. The evidence also establishes that the answer given to question 11 that the insured had never been treated for any disease of the heart was untrue. And,

[1] The seventh question of the application was in that portion which was filled out by the applicant. It was preceded by the recitation: "As a condition to the reinstatement of this insurance, I do hereby certify that the answers to the following questions are true to the best of my knowledge and belief * * *" (R. 169).

The eleventh question was in that portion of the application entitled "Medical Examination. * * * Applicant's Own Statement." This portion was undoubtedly filled out by the medical examiner pursuant to questions propounded to the applicant, but was signed by the applicant in the presence of the medical examiner (R. 171–172).

finally, the evidence shows that each of these misrepresentations was known by the insured to be untrue at the time he made it, that each of them was material to the risk, that each of them was made with the intention to deceive, and that each of them was relied upon by the Government in issuing the policy.

We discuss each of these misrepresentations separately below. We believe that, with respect to each of them, a directed verdict on the issue of fraud was required. But we are, of course, required to establish only that the evidence shows without contradiction that one of the answers was fraudulently made, for fraud shown by uncontradicted evidence with respect to any one answer required a directed verdict for the Government.

It is scarcely disputed that the insured sought to defraud the Government, either in his application for reinstatement of the insurance or in his subsequent applications for retirement, disability compensation, vocational training, and pension (hereinafter collectively referred to as "applications for benefits"). In his application for reinstatement signed on June 21, 1927, the insured pictured himself as a well man who had never been treated for any serious disease and who had not been ill or even consulted a physician since 1920, when his insurance had lapsed—in other words, as a first-class insurance risk. Yet, on August 27, 1928, within 15 months after the appli-

cation for reinstatement, he put in a claim for disability compensation. At that time, when it was to his interest to picture himself as a badly disabled veteran, he asserted that he had been afflicted since 1918 with sinusitis, ethmoiditis, and myocarditis (R. 197). He made substantially the same representations on May 24, 1929, when he filed a claim for Emergency Officers Retirement benefits (R. 199–200). Again, in December 1933, when he claimed a soldier's pension, he asserted that he had been afflicted since 1918 with sinusitis and myocarditis, and, further, that he was suffering from a duodenal ulcer, resulting from a gastro-intestinal upset during his period of military service (R. 202–206).[4] In the 1933 pension claim, too, he listed several doctors whom he had consulted between 1920 and 1927, this representation, of course, being in direct contravention of his representation in his 1927 application for reinstatement that he had never consulted a physician in regard to his health during that period.

Petitioner does not deny the conflict between the insured's representations in his application for reinstatement of insurance and his representations in his applications for benefits, but urges that it was for the jury to decide which assertions were true. We believe, however, that, certainly with respect to one representation in

[4] See also the insured's claim for disability allowance filed July 14, 1930 (R. 200–201).

the application for reinstatement, and probably with respect to all of the representations upon which we rely, there is no evidence in the record conflicting with the Government's proof that the insured answered falsely and fraudulently. And, as we have stated, if any single one of the representations is shown by the uncontradicted evidence to have been fraudulent, the Government was entitled to a directed verdict, even though a conflict of evidence may be thought to exist with respect to the fraudulent nature of the other representations.

We discuss first, then, the representation concerning the fraudulent nature of which we think no possible conflict of evidence can be said to exist—namely, that the insured had not consulted a physician with regard to his health between March 1920 and June 1927. We show that the undisputed evidence establishes that this representation was false, that it was made with reference to a material fact, that it was made with knowledge of its falsity, that it was made with intention to deceive and be acted upon, and that the policy was issued in reliance upon its truth. Following that discussion, we consider the evidence concerning the representations that the insured had not been ill between March 1920 and June 1927, that he had never been treated for any disease of the heart, and that he had not been

prevented by reason of ill health from attending his usual occupation.'

A. THE REPRESENTATION THAT THE INSURED HAD NOT CONSULTED A PHYSICIAN IN REGARD TO HIS HEALTH BETWEEN MARCH 1920 AND JUNE 1927 WAS FRAUDULENT

Falsity.—The falsity of this representation was affirmatively established by the testimony of Dr. Glickman that he was consulted by the insured and that he had treated the insured from January 16 to January 25, 1927, for sinusitis and ethmoiditis (R. 109).

An affidavit executed by Dr. Glickman on September 7, 1928 (R. 119–120, 214) likewise refers to this consultation, while an affidavit executed by the insured on the same date (R. 208–209) recites that he was treated by a physician in January 1927 for eight days for sinusitis, and that during this period he was confined to bed.[10]

[9] The Government's answer to the complaint (R. 10) alleges fraud only with respect to the insured's answers to question 11. However, the record shows that the case was actually tried as though the pleadings raised an issue of fraud with respect to each of the representations upon which the Government relies. Since no objection was made by petitioner, these issues actually tried are to be treated as though they had been raised in the pleadings. Rule 15 (b) of the Rules of Civil Procedure for the District Courts.

[10] The affidavits executed on September 7, 1928, by Dr. Glickman and the insured were submitted by the latter as supplementary to a compensation claim executed by him on August 27, 1928, and witnessed by Dr. Glickman (R. 197–

There is no conflicting evidence with respect to the fact of this consultation. While petitioner and others closely associated with the insured testified that they were not aware that the insured had ever been treated by a physician (R. 18–19, 41, 58), this testimony is obviously negative in character and does not contradict the direct testimony of Dr. Glickman or the evidence furnished by the insured's own statement.

The falsity of the representation is further shown by undisputed evidence that the insured sought and obtained a gastro-intestinal examination by physicians at the Veterans Hospital at Sioux Falls, South Dakota, on April 6, 1925. The insured made several statements, subsequent to the reinstatement of his insurance and in support of claims for disability benefits other than insurance, that this examination had been made at his request (R. 185, 187, 211). Petitioner herself testified that a gastro-intestinal examination of the insured had been made at the Sioux Falls Hospital (R. 37–38). Excerpts from the report of this examination are contained in the record and reveal that the findings resulted in a diagnosis of "Suspected duodenal pathology" (R. 196).

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199). Hence, the failure of the insured to refer to the treatment by Dr. Glickman, in response to a question in the form of the compensation claim itself, designed to elicit it (R. 198), was plainly an error corrected by the affidavits submitted with the claim.

Knowledge of falsity.—There can be no doubt that the insured knew of the falsity of his representation that he had not consulted a physician between March 1920 and June 1927.

Knowledge of falsity in the omission of any reference to consultation with respect to sinusitis is established by the fact that, on September 27, 1928, the insured filed an affidavit in connection with a claim for disability compensation in which he set forth this specific consultation with Dr. Glickman. It should be noted, too, that this consultation occurred just five months prior to the execution of the reinstatement application and was for the purpose of securing treatment for an acute, painful exacerbation of a condition which had existed for at least eight years.

Dr. Glickman's testimony and affidavit of September 7, 1928, shows that when he treated the insured in January 1927 for sinusitis and ethmoiditis he made an examination which disclosed a bloody discharge from the nose and severe pain between the eyes (R. 109), necessitating treatment by "Argyrol installations and packs" and "serum therapy" (R. 120). He stated, moreover, that the condition for which he treated the insured was incurable (R. 120), and that the insured—who was an eye, ear, nose and throat specialist (R. 110, 177)—had himself expressly recognized it as "a recurrence of a chronic condition" (R. 110). Other evidence showed that the condition had

existed in a severe form since 1919. See testimony of Dr. French (R. 123–124) and Dr. Burke (R. 125–126).

Subsequent to the reinstatement, the insured recalled the facts of medical consultation and treatment for sinusitis prior to June 1927 (R. 208–209; see also R. 204).

Knowledge of falsity in the omission from the application of any reference to the consultation in 1925 for gastro-intestinal disorder is established by the fact that the insured, subsequent to the reinstatement, recalled the consultation and relied upon the resultant findings and diagnosis in support of claims asserted by him for benefits other than insurance. Moreover, the condition disclosed as a result of the consultation was obviously too serious to have been forgotten by the insured, especially since there is testimony that the insured suspected the possibility, prior to the consultation, of an even more serious condition than was disclosed.

On November 28, 1931, the insured made reference, in a written statement supplementing his claim for Emergency Officers Retirement benefits, to a severe gastric upset experienced by him during his military service, and stated that it turned out to be the forerunner of duodenal ulcer, which perforated in 1920 and again in 1925, and that because of constant distress and tarry stools, "I requested a GI. [gastro-intestinal] X-ray

* * *. The diagnosis at that time was duodenal ulcer active." (R. 211; see also R. 185, 187, 204.)

Petitioner testified that the motive of the insured in the consultation with physicians in April 1925, when the gastro-intestinal examination was made, was to "have a check-up" because of a family history of cancer (R. 38).

Materiality.—In the absence of any evidence to the contrary, the representation of the insured that he had not consulted a physician regarding his health will be presumed to be material simply by reason of the fact that the insurer made specific inquiry with respect to that subject. *Bella S. S. Co.* v. *Insurance Co. of North America,* 5 F. (2d) 570, 572 (C. C. A. 4); *Kerr* v. *Union Marine Insurance Co.,* 130 Fed. 415, 417 (C. C. A. 6); *Metropolitan Life Insurance Co.* v. *Madden,* 117 F. (2d) 446, 451 (C. C. A. 5).

It is also manifest that the representation was material *per se.* Mere mention of the consultation with Dr. Glickman would have opened the gate to an extensive history of chronic sinusitis and ethmoiditis. Likewise, disclosure of the gastro-intestinal examination would have led to the revelation of a history of abdominal disorder. It is thus apparent, we believe, that a truthful answer in this single particular would have made available to the insurer abundant information pertinent to a determination of whether the risk of issuing insurance

against total permanent disability and death should be assumed.[11]

It is true that the Circuit Court of Appeals suggests in its opinion that, so far as the falsity of insured's representation was established by the consultation relative to sinusitis, such consultation "might appear immaterial in view of the fact that there was no reference to a disease of the nose or sinuses in the eleventh question."[12] (R. 251.) But the representation that the insured had not consulted a physician was contained in his answer to question 7, not in his answer to question 11. The possible view of the court that the scope of question 7 should be regarded as limited to the conditions mentioned in question 11 is not, we believe, tenable. The seventh question was obviously designed to elicit information regarding relatively recent illness of any character (during the period since the lapse of the insurance) deemed pertinent because of its proximity in time to the possible assumption

[11] The insured died suddenly. Upon the evening of September 20, 1934, he stated that he did not feel well and retired about 8 o'clock. He was found dead the next morning, September 21, 1934. The cause of death shown on the death certificate was "coronary thrombosis, sudden death, myocarditis chronic, chronic sinusitis, nasal accessory sinusitis, with acute exacerbation" (R. 78). The undisputed testimony establishes that the insured's heart condition was induced and aggravated by infection from his sinusitis and duodenal ulcer (R. 81–82, 128–129, 145–146).

[12] The eleventh question sought information as to whether the applicant had ever been treated for a limited number of enumerated conditions (R. 171–172).

of risk under consideration; question 11 was plainly intended to secure information regarding conditions deemed to be pertinent, regardless of their remoteness in time. The latter conditions were obviously specified to avoid any possibility that the applicant might forget them.

Intention to deceive.—The insured's intention to deceive is presumed, as a matter of law, from the fact that he made the representation with knowledge of its falsity. *Mutual Life Insurance Co.* v. *Hilton-Green,* 241 U. S. 613, 622; *Claflin* v. *Commonwealth Ins. Co.,* 110 U. S. 81, 95. See also *Stipcich* v. *Metropolitan Life Ins. Co.,* 277 U. S. 311, 316–317, pointing out that "even the most unsophisticated person must know that in answering the questionnaire and submitting it to the insurer he is furnishing the data on the basis of which the company will decide whether, by issuing a policy, it wishes to insure him." Moreover, the evidence previously recited makes it manifest that there was on the insured's part a conscious design to deceive, and there is no evidence to warrant any other inference.

Reliance.—The insurance policy was, in fact, reinstated in reliance upon the insured's representations. This is established by the undisputed testimony of an official of the Veterans' Administration serving as a technical advisor on insurance (R. 139). Moreover, he testified that if the application had revealed that a physician had been con-

sulted, an investigation would have been made to determine what condition was found upon such consultation (R. 137).

B. THE REPRESENTATIONS THAT THE INSURED HAD NOT BEEN ILL SINCE MARCH 1920 AND THAT HE HAD NEVER BEEN TREATED FOR ANY DISEASE OF THE HEART WERE FRAUDULENT

The undisputed evidence establishes that the insured had in fact been ill by reason of sinusitis and ethmoiditis in January 1927, within six months prior to the reinstatement of the insurance. This evidence has been discussed (*supra*, pp. 15, 17).

Likewise, there has been set out in detail (*supra*, pp. 16, 18–19), the uncontradicted evidence disclosing findings and symptoms indicative of the existence of duodenal ulcer for a substantial period of time prior to the reinstatement of the insurance, and the conclusion of the insured, who was a physician, that he had had active duodenal ulcer as early as 1920.

Subsequent to reinstatement, the insured executed sworn statements on August 7, 1928, and September 7, 1928, that he was afflicted with myocarditis which had originated in 1918, as the result of influenza; that during the years following his discharge from the service (1919), he experienced constant "air hunger," which was still noticeable in 1928, and which was regarded by him as due to myocarditis (R. 197, 208; see also R. 189, 200, 202). Also, in a letter dated November 28, 1931,

the insured stated, with reference to the diagnosis of myocarditis during service (R. 210–211):

> The incidents preceding and leading to the diagnosis of acute myocarditis are these: one night when Major DeWeise came in he found me sitting on the side of the bed. On being told that I was doing it because of difficulty in getting my breath and that I thot [*sic.*] it was due to soft coal gas, he examined my chest with stethoscope and said: Man, your heart is "shot." He got me some medicine which relieved the symptoms and which [I] continued to take as per his directions for several weeks. He told me I had acute myocarditis and that it would be necessary to take things rather quietly for some time.

In concluding his letter, the insured stated, apparently with reference to the attack in 1918 (R. 211):

> I never had a day of sickness in my life before this and I do not believe I have had an entirely well one since.

C. THE REPRESENTATION THAT THE INSURED HAD NOT BEEN PREVENTED BY ILL HEALTH FROM ATTENDING HIS USUAL OCCUPATION WAS FRAUDULENT

The evidence established that in 1925 the insured abandoned a private practice as a physician of over twenty years (R. 177, 200), with an income of more than $7,000 a year, to accept employment with the Government at a salary of $3,800 per year (R. 189). His employment in the Government service thereafter until the date of his death was

that of a physician at various veterans' hospitals and homes (R. 19–20, 27, 40–41, 63).

There was undisputed evidence that he abandoned his private practice by reason of ill health. Dr. Burke, an acquaintance, testified that insured had talked with him in 1922 and 1923 regarding his sinusitis (R. 125), and had stated an intention to *give up his* private practice because "it was too hard, and he had too many headaches," and "he had considerable trouble with his sinuses" (R. 126). And on September 7, 1928, the insured signed a statement which recited that "Since discharge the sinusitis has become more severe with constant frontal headaches making it necessary for me to give up my practice and find employment where I could be inside. Cannot stand any exposure to cold" (R. 208). Also, on October 10, 1928, the insured, in relating his industrial history, stated that while in private practice he had lost about half time from work on account of sinus trouble (R. 209).

It may be argued, of course, that this evidence shows merely a change of activity within the field of the single occupation of medicine, and that question 7 should be construed literally as referring to the effect of ill health upon the ability to pursue the occupation itself, rather than upon the ability to continue in the character of activity usually engaged in. This technical interpretation of question 7 would, however, be repugnant to the clear pur-

pose of the insurer in asking it, and it strains credulity to believe that a person of the education, training, and employment background of the insured could have thought that such a legalistic interpretation was warranted. We believe, therefore, that the insured's negative answer to this portion of question 7, coupled with nondisclosure elsewhere in the application of the pertinent information, constituted a breach of his obligation to exercise good faith.

The evidence discussed makes completely clear, we think, that the insured, who was a physician employed by the Veterans' Administration in his professional capacity, knew that there existed most substantial reasons why his application for the reinstatement of insurance should either not be granted at all, or, at the very least, why it should not be granted until after most careful consideration of numerous factors affecting the risk, and that the insured fraudulently failed to disclose those factors.

II

THE PORTIONS OF THE RECORD UPON WHICH PETITIONER RELIES DO NOT CREATE A CONFLICT OF EVIDENCE JUSTIFYING SUBMISSION OF THE ISSUE OF FRAUD TO THE JURY

1. In her brief in support of the petition for a writ of certiorari (Pet. 11–19), now adopted as part of her argument on the merits (Br. 3), petitioner urges primarily that there was evidence

tending to show that the insured was in good health when he applied for the reinstatement of his insurance in June 1927. We concede that there is some evidence to this effect, but we deny that it creates any conflict of evidence on the determinative issue of fraud.

The question whether the insured was a good insurance risk and entitled to reinstate his insurance was for the exclusive determination of the Administrator of Veterans' Affairs (*Meadows* v. *United States*, 281 U. S. 271, 275; see also *Armstrong* v. *United States*, 16 F. (2d) 387, 389 (C. C. A. 8); *Maddox* v. *United States*, 16 F. (2d) 390, 391 (C. C. A. 8)), and in the determination of that question the Administrator was entitled to a full and fair disclosure of the information sought by him and deemed by him to be material. The issue in litigation, therefore, was whether the insured made fraudulent representations. As we have shown, the undisputed evidence establishes that he did make such representations and that they had the effect of depriving the Administrator of information deemed by him to be essential to the proper performance of his duty of determining whether the insurance should issue. The Government's contentions are not rested, as petitioner apparently assumes, upon the narrow ground that the insured was not in good health when he applied for reinstatement. A person conclusively shown to be in good health at a particular time may nevertheless reasonably be re-

garded as a poor insurance risk by reason of past illnesses and increased susceptibility to future disease, disability, and early death.

Nor can the evidence upon which petitioner relies in respect of the false issue of good health at the time of the application be deemed to have created any real conflict for jury consideration with reference to the true issue of fraud. This evidence consisted broadly of the following:

Testimony of petitioner and other lay witnesses closely associated with the insured to the effect that they were unaware that he had been ill except for a condition described by them as "colds" two or three times each winter, that, so far as they knew, he had never been treated by a physician, and that he had led a relatively active and normal life (R. 20–27, 29, 34, 46–49, 50, 56–58); reports of medical examinations prior to reinstatement, including the report submitted with the application for reinstatement, in which no physical disorders were discovered (R. 172–173, 176, 182–183); a statement made by the insured on December 3, 1924, indicating good health then and prior thereto (R. 177–178); and reports of certain medical examinations, made subsequent to reinstatement, in which ailments claimed by the insured were either not found or were found to exist in a lesser degree than claimed (R. 185–186, 191–192, 196)."[13]

[13] Other reports subsequent to reinstatement disclosed or indicated the disorders of which complaint was made (R. 188, 190, 192, 193, 195).

The negative evidence that the petitioner and other persons associated with the insured were unaware of his ailments does not refute the positive evidence showing that he was in fact ill on occasions between the lapse of his insurance and the request for its reinstatement, and that he consulted physicians and received treatment for his disorders. The disabilities claimed by him were of a character not ordinarily recognizable by laymen. Thus, with reference to his heart condition, the insured himself stated (R. 213):

> It should be well known that a degenerative type of myocarditis is the most treacherous form of heart disease known, as long as compensation keeps up there are very fine manifest symptoms and that when decompensation does occur it is usually complete and final.

And Dr. Thompson, head of the hospital at which the insured last worked, testified, in effect, that sinusitis and myocarditis would not ordinarily be detectable except upon careful medical examination (R. 77). Moreover, it is apparent that petitioner was unaware of the findings made upon the gastro-intestinal examination of insured in 1925, or unable to recognize their significance (R. 31, 38), and that she could not distinguish between sinusitis and the common cold (R. 32–34). However, the insured himself readily made the appropriate distinction in requesting Government sick leave (R. 76–77).

That medical examinations on widely separated occasions revealed no illness is evidence that there was an absence of illness at the time of each such examination but does not show that illness did not exist at other times. It has, of course, no probative value with respect to the question as to whether the insured consulted physicians upon other occasions with respect to his health, or was treated by them for physical ailments.

Thus, the findings of Dr. French in 1924 (R. 182) and Dr. Pearce in 1925 (R. 183–184) that the insured was not then ill, cannot be regarded as in conflict with Dr. Glickman's testimony that by reason of illness existing in 1927, the insured consulted him and received treatment, or the testimony of Dr. Burke that the insured, in 1922 and 1923, complained that he was afflicted with sinusitis, and that he intended, because of his illness, to abandon the private practice of medicine. Neither can the findings of Dr. French and Dr. Pearce be deemed inconsistent with the evidence showing that the insured was treated for a heart condition in 1918.

2. Petitioner attacks (Br. 3–4) the statement of the Circuit Court of Appeals that "Certainly it appears to us that the Government is entitled to rely upon statements furnished by Pence for a different purpose, to prove the falsity of the information furnished for the purpose of reinstating the policy." She states that "By 'rely upon state-

ments' the Court of Appeals really means that these statements proved the falsity of the statements in the application for reinstatement" and contends, in effect, that the insured merely made inconsistent statements, which presented a question for the jury whether the representations made in the application for reinstatement or the representations made in the applications for benefits were false.

It thus appears that petitioner regards the insured's representations in his application for reinstatement as evidence of their own truthfulness, with the result that the Government's evidence that the representations were fraudulent, although otherwise undisputed in essential particulars, merely creates a conflict of evidence requiring jury consideration. Petitioner's error in this respect lies in her failure to realize that the insured's representations in his application for reinstatement are not evidence of their own truth or falsity. Upon the issue whether these representations were fraudulent, the representations themselves obviously have no probative value whatever; they are evidence merely for the purpose of showing what they are and, thus, the nature of the issue created by the Government's allegation that they were fraudulent. If the law were otherwise, it would follow that a verdict could never be directed in favor of a party alleging fraud in any case in which the falsity of a representation was in issue.

Yet, verdicts have frequently been directed in such circumstances. Cf. *Bella S. S. Co.* v. *Insurance Co. of North America*, 5 F. (2d) 570 (C. C. A. 4); *Aetna Life Ins. Co.* v. *Perron*, 69 F. (2d) 401 (C. C. A. 7); *Aetna Life Ins. Co.* v. *Bolding*, 57 F. (2d) 626 (C. C. A. 5); *Columbian National Life Ins. Co.* v. *Rodgers*, 93 F. (2d) 740 (C. C. A. 10).

III

THE CIRCUIT COURT OF APPEALS PROPERLY DENIED PETITIONER'S CONTENTION THAT IT LACKED JURISDICTION TO HEAR THE APPEAL

Petitioner argues at some length in her brief in support of the petition for a writ of certiorari (Pet. 24–27) that because of lack of prompt compliance with the provisions of Rule 9 of the Circuit Court of Appeals, that court was without jurisdiction to hear and determine the appeal on its merits.[14]

Rule 9 (*supra*, pp. 2–3), provides that no appeal will be considered unless a statement of points setting out each error asserted and intended to be urged is filed with the Clerk of the District Court for inclusion in the record on appeal. The rule recites no specific time within which the statement must be filed, but presumably it was intended that it should accompany the record transmitted to the appellate court.

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[14] In her brief on the merits, petitioner states that "Although we do not abandon the point we prefer to rest our case on the merits * * *" (Br. 11).

However, Rule 9 does not purport to be jurisdictional, and that it is not regarded as jurisdictional by the court which promulgated it is conclusively shown by the decision in this very case. The rule was adopted on November 10, 1939, subsequent to the effective date of the Rules of Civil Procedure, and was intended to harmonize with them.[15] Yet, if Rule 9 were interpreted as a jurisdictional requirement, as petitioner urges, it would be repugnant at least in principle to several of the Rules of Civil Procedure. Rule 73 (a) (*supra*, p. 3) provides that "Failure of the appellant to take any of the further steps [subsequent to filing the notice of appeal] to secure the review of the judgment appealed from does not affect the validity of the appeal * * *." Rule 75 (d) (*supra*, p. 4) requires the filing in certain cases of a statement of points to be relied upon. Yet, failure to file such a statement in any case in which it may be required does not affect the jurisdiction of the appellate court under the plain provisions of Rule 73 (a). Cf. *Adams* v. *New York C. & St. L. R. Co.*, 121 F. (2d) 808, 809 (C. C. A. 7). While Rule 73 (g) (*supra*, pp. 3–4) limits the power of the Dis-

[15] In promulgating this and other rules, the Circuit Court of Appeals stated: "These rules have been adopted by the Court in an effort to secure greater uniformity of practice in the United States Circuit Courts of Appeal and to harmonize with the Rules of Civil Procedure for the District Courts of the United States, adopted by the Supreme Court, effective September 16, 1938."

trict Court to extend the time for filing the record in the Circuit Court of Appeals, the Circuit Court of Appeals may permit the filing of the record after expiration of the time allowed by the District Court, or the time which the District Court might have allowed. *Ainsworth* v. *Gill Glass and Fixture Co.*, 104 F. (2d) 83, 85 (C. C. A. 3); *Miller* v. *United States*, 117 F. (2d) 256, 257 (C. C. A. 7); *Johnson* v. *Wilson*, 118 F. (2d) 557, 558 (C. C. A. 9).

By analogy, also, Rule 75 (h) (*supra*, pp. 4–5) supports the view that Rule 9 of the Circuit Court of Appeals should not be regarded as jurisdictional. Rule 75 (h) authorizes the supplementing of a record on appeal after the original record has been filed, the obvious purpose being to prevent submission of a case to the Circuit Court of Appeals upon an inadequate record.

The Circuit Court of Appeals could have imposed an appropriate penalty for failure of the Government to comply promptly with Rule 9, including, presumably, the dismissal of the appeal (cf. Rule 73 (a)). Undoubtedly it would have done so had any prejudice resulted to the petitioner. It is plain, however, in the present case, that no prejudice resulted. A record complete in every respect except the statement of points required by Rule 9 was promptly filed and made available to petitioner. And at the time the supplemental record containing the statement of points was filed on March 3, 1941 (R. 245), neither party had filed a

brief and the case did not come on for oral argument until April 18, 1941 (R. 246). Indeed, petitioner claims no prejudice.

CONCLUSION

For the reasons stated, we respectfully submit that the judgment of the Circuit Court of Appeals should be affirmed.

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MARCH 1942.

U. S. GOVERNMENT PRINTING OFFICE: 1942

SUPREME COURT OF THE UNITED STATES.

No. 665.—October Term, 1941.

Harriett V. Pence, Petitioner, vs. The United States of America. } On Writ of Certiorari to the United States Circuit Court of Appeals for the Seventh Circuit.

[May 11, 1942.]

Mr. Justice Jackson delivered the opinion of the Court.

This action was begun in the United States District Court for the Eastern District of Wisconsin by the petitioner, a widow, as sole beneficiary of a policy of United States Government life insurance issued to her deceased husband, Doctor Lawrence W. Pence. The only contested issue was raised by the Government's affirmative defense that the policy had been reinstated as the result of fraudulent representations in Doctor Pence's application for reinstatement of the policy after it had lapsed for nonpayment of premium.

At the close of the evidence in the trial court the Government moved for a directed verdict in its favor. The trial judge withheld a ruling on the motion under Rule 50(b) of the Rules of Civil Procedure and submitted the case to the jury, which returned a general verdict for the petitioner. The Government then moved under Rule 50(b) for judgment notwithstanding the verdict, and, in the alternative, for a new trial. The trial judge denied both motions and entered judgment on the verdict for the petitioner. The Government appealed to the Circuit Court of Appeals for the Seventh Circuit, which held, with one judge dissenting, that the evidence was insufficient to establish a case for the consideration of the jury and that there was no independent ground requiring that a new trial be granted. It reversed the judgment of the District Court and remanded the cause for further proceedings in harmony with its opinion. 121 F. 2d 804. We granted certiorari. 314 U. S. 602.

Petitioner contends that the evidence raised a question of fact for the consideration of the jury, and that the decision of the

Circuit Court of Appeals therefore denies her the right to trial by jury.[1]

Doctor Pence had been a physician and medical officer in the military service of the United States from August 7, 1918, to January 9, 1919. While in the service he obtained a $10,000 policy of yearly renewable War Risk term insurance, which he allowed to lapse on March 2, 1920, for nonpayment of the premium due on February 1, 1920. In 1925 he gave up a private medical practice to accept employment as a physician with the Government, acting thereafter as a specialist in eye, ear, nose, and throat diseases at various veterans' hospitals and homes maintained by the Government. On June 21, 1927, Pence applied for reinstatement and conversion of the lapsed term policy. The policy was accordingly reinstated and converted, effective July 1, 1927; and, except for the question of fraud,[2] was in force at the time of his death on September 21, 1934.

In his application for reinstatement Pence categorically denied, among other things, that he had ever been treated for any disease of the throat, heart or stomach. So also did he deny that since the lapse of the policy he had consulted any physician in regard to his health, or had been ill or prevented by ill health from attending to his usual occupation.

At the trial there was submitted in evidence a communication from the Regional Medical Officer at Sioux Falls, South Dakota, to the Manager of the Veterans' Administration in Milwaukee, Wisconsin, and dated December 9, 1931. This reported that a gastro-intestinal X-ray examination had been made of Pence at the Sioux Falls Veterans' Hospital on April 6, 1925, and had resulted in a diagnosis of "suspected duodenal pathology." Pence made several statements, subsequent to the reinstatement of his insurance and in support of claims for disability benefits from the Government, that this examination had been made at his request. Mrs. Pence admitted that she knew that such an examination had been made.

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[1] This right was conferred by amendment to § 19 of the World War Veterans Act, 43 Stat. 1302, 38 U. S. C. § 445. Whitney v. United States, 8 F. 2d 476; Hacker v. United States, 16 F. 2d 702; United States v. Salmon, 42 F. 2d 353; United States v. Green, 107 F. 2d 19; H. R. Rep. No. 1518, 68th Cong., 2d Sess., p. 2.

[2] A defense on this ground is authorized by § 307 of the World War Veterans Act, 38 U. S. C. § 518.

About fifteen months after his application for reinstatement, and on August 27, 1928, Pence applied to the Government for disability compensation, claiming that he was disabled by chronic sinusitis, ethmoiditis, atrophic rhinitis, and by myocarditis. On September 7, 1928, he executed and submitted a sworn statement in support of his application for disability compensation that he suffered from the following disabilities: "sinusitis, frontal, ethmoiditis, chronic, atrophic rhinitis, chronic, with loss of sense of smell, myocarditis, chronic . . . incurred . . . on or about October 1918." He also stated "That a physician was called in to treat me on Jan. 1927, when he pronounced my disability sinusitis, frontal, acute exacerbation and prescribed serum and local treatment tending to induce drainage. Treatment was carried out by myself. Was confined to bed for 8 days." Together with this he submitted a supporting "Physician's Affidavit," by Doctor L. Grant Glickman, a practicing physician stationed at the time of the asserted examination at the National Home at Leavenworth, Kansas, where Pence was stationed; and employed at the time of the trial by the Veterans' Administration at Fort Snelling, Minnesota.[3]

In 1931 and 1933 Pence made statements in support of other claims for benefits similar to those set forth above in that they contradicted the representations made in his application for reinstatement involved in this case. On November 28, 1931, he submitted a statement in support of an application for retirement, to the effect that in 1918 a camp physician by whose authority he remained in barracks under special care while in service examined his heart and told him it was "shot"; that he had acute myocarditis and a severe gastric upset which "turned out to be a forerunner of duodenal ulcer which perforated in 1920 and again in 1925"; and that because of distress and certain symptoms he later re-

[3] This affidavit contained the following: "I first examined the claimant on Jan. 16, 1927. His complaint at that time was: Frontal sinusitis & Ethmoiditis, chronic. Upon physical examination I found the following symptoms present: Headache, severe; bloody purulent discharge from nose. I diagnosed the injury or disease as Chronic ethmoiditis & frontal sinusitis with an auto exacerbation. The prognosis was fair but incurable. I do believe the claimant's disability is attributable to his military service, for the following reasons: Statement of claimant that above trouble followed influenza in service. Never troubled before that time with above disabilities. Claimant continued under my care until Jan. 25, 1927, during which time I treated him as follows: Argyrol instillations & packs. Serum therapy."

quested a gastro-intestinal examination at the Veterans' Bureau office at Sioux Falls, South Dakota. He concluded his statement: "I never had a day of sickness in my life before this and I do not believe I have had an entirely well one since." On December 8, 1933, he submitted a sworn application for pension for disability resulting from active military service, stating that since the beginning of service one civilian physician had treated him for sinusitis and myocarditis; and four others for sinusitis alone. One of the latter examinations was stated to have been made by Doctor Glickman in 1926, and another was stated to have been made at a time after the lapse of the policy in suit.

Doctor Glickman was produced at the trial as a witness for the Government, in whose employ he still was at the time. The trial judge ruled out as improper, questions by petitioner's counsel bearing upon the question whether disciplinary action had been taken against Glickman and others because of the execution of affidavits in support of Pence's claim for disability compensation and other of his claims. Upon being asked whether he had an independent recollection of the examination referred to, he stated that he had copies of "records", but not the "originals." The Government's attorney then asked: "Well, Doctor, do you have a recollection of your examination—refresh your recollection of your examination of Dr. Lawrence Pence in January, 1927." Glickman answered "I do." The Government could not locate the record of the treatment made on Glickman's report as officer of the day —apparently the only record made of the treatment—and it was not produced at the trial.

Glickman testified further as follows: Pence called upon him for treatment on January 16, 1927, while he was acting as officer of the day. He concluded that Pence was suffering from sinusitis and ethmoiditis. Pence knew what his findings were, and stated that he was suffering from a recurrence of a chronic condition. Glickman treated Pence at Pence's home on two or three occasions between January 16 and January 25. Mrs. Pence was at home then, although perhaps not on all occasions. Pence had no cold, but Glickman prescribed a cold serum for him, and also some argyrol packs.

Mrs. Pence testified, however, that: She had no knowledge that her husband had consulted a physician. She was close to him, and constantly with him, and believed that he would have told

her of anything seriously the matter with him. He never told her, however, of consulting a physician, or that he suffered from sinusitis, ethmoiditis, or myocarditis. Her husband led an active, vigorous, life, and was never confined to bed except by occasional colds, and suffered from no other sickness. It appeared from her testimony, however, that she was unable to differentiate between a "cold" and a sinus infection.

Pence's two sons and two friends also testified to his active life and apparent good health.

With the evidence in this condition, the Circuit Court of Appeals held that the District Court erred in refusing to withdraw the case from the jury.

The Government, which the Circuit Court of Appeals held was entitled to a directed verdict, had the burden of proof on the issue of fraud. Under the circumstances we have recited, the credibility of Doctor Glickman, its witness, was clearly for the jury. The evidence of the gastro-intestinal examination was likewise insufficient to sustain the direction of a verdict. We assume without deciding that the jury could not have refused to believe that such an examination had been made. Yet the jury could have properly refused to deduce from this all the necessary elements of the defense of fraud, established by our decisions to be: (1) a false representation (2) in reference to a material fact (3) made with knowledge of its falsity (4) and with the intent to deceive (5) with action taken in reliance upon the representation.[4]

The case of the Government for a directed verdict rests, therefore, upon the statements of Pence made after the reinstatement of his insurance and contradicting the representations in his application for reinstatement. Their admissibility as against the beneficiary-plaintiff, Mrs. Pence, is not in issue on this record, for they were introduced by the Government and received in evidence without objection.[5]

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[4] Claflin v. Commonwealth Ins. Co., 110 U. S. 81; Lehigh Zinc & Iron Co. v. Bamford, 150 U. S. 665, 673; Mutual Life Ins. Co. v. Hilton-Green, 241 U. S. 613; cf. Derry v. Peek, 14 App. Cas. 337, 374.

[5] Compare Truelsch v. Miller, 186 Wis. 239, 250; Connecticut Mutual Life Ins. Co. v. Hillmon, 188 U. S. 208. It does not appear from the report of the *Hillmon* case whether the insured had the power to change the beneficiary, as he did in the present case. § 301 of the World War Veterans Act, 38 U. S. C. § 512. The effect of such a power to make the insured's statements admissible against the beneficiary has frequently been dealt with by the courts and commentators. 4 Wigmore, Evidence (2d ed.) 146, note 6; Kales, Admissibility of Declarations of the Insured against the Beneficiary, 6 Columbia Law Review 509; Morgan, The Rationale of Vicarious Admissions, 42 Har-

Pence's representations in the application were not evidence of their own veracity.[6] His later contrary statements were repeated and usually under oath; they are in no way improbable, and are the statements of one who, being himself a doctor, spoke with knowledge of the subject and bearing of his statements. His admissions left no room for conjecture as to the falsity of the previous statements in the application, and of his knowledge of such falsity. From these facts the requisite intent to defraud is presumed,[7] and therefore need not be proven in the absence of countervailing evidence. Materiality and reliance were conclusively established by evidence introduced at the trial, if indeed such proof were needed.

No evidence in the case served in any way to contradict, qualify, or explain Pence's admissions.[8] We are of opinion that in the absence of any such evidence his admissions established so overwhelming a case in favor of the Government as to require the direction of a verdict in its favor,[9] and the decision of the Circuit Court of Appeals is, therefore,

Affirmed.

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vard Law Review 461, 477-78; Finale, The Admissibility of Declarations of the Assured in Life Insurance Litigation, 8 St. John's Law Review 258; 4 Minnesota Law Review 359.

The cash, loan, and other values of the policy in suit to Pence at the time of his various statements contradicting the representations in his application for reinstatement and conversion of the policy in suit do not appear in the record. Compare § 301 of the World War Veterans Act, 38 U. S. C. § 512.

[6] If the law were otherwise, it would follow that a verdict could never be directed in favor of a party alleging fraud in any case in which the falsity of a representation was in issue. Yet, verdicts have frequently been directed in such circumstances. Cf. Bella S. S. Co. v. Ins. Co. of North America, 5 F. 2d 570; Aetna Life Ins. Co. v. Bolding, 57 F. 2d 626; Aetna Life Ins. Co. v. Perron, 69 F. 2d 401, certiorari denied, 292 U. S. 570; Columbian National Life Ins. Co. v. Rodgers, 93 F. 2d 740.

[7] Claflin v. Commonwealth Ins. Co., 110 U. S. 81, 95; Mutual Life Ins. Co. v. Hilton-Green, 241 U. S. 613, 622; cf. Agnew v. United States, 165 U. S. 36, 53; Stipcich v. Metropolitan Life Ins. Co., 277 U. S. 311, 316-317.

[8] The denial of Pence's various claims is in no way inconsistent with the truth of his admissions here involved, since his claims were allowable only in the event of actual physical disability at the time. That a man is not presently disabled in no way militates against the truth of statements that he had previously consulted a physician, etc.

[9] Wilkinson v. Kitchin, 1 Lord Raymond 89; Decker v. Pope, 1 Selwyn, Nisi Prius (13th ed.) 91; Hendrick v. Lindsay, 3 Otto 143; Arthur v. Morgan, 112 U. S. 495; Anderson County Commissioners v. Beal, 113 U. S. 227, 241-242; Chesapeake & Ohio Ry. v. Martin, 283 U. S. 209, 216.

SUPREME COURT OF THE UNITED STATES.

No. 665.—October Term, 1941.

Harriet V. Pence, Petitioner, vs. The United States of America. } On Writ of Certiorari to the United States Circuit Court of Appeals for the Seventh Circuit.

[May 11, 1942.]

Mr. Justice Murphy, dissenting.

In view of the high value and importance attached by custom and tradition to the right of jury trial as a feature of our federal jurisprudence, and the significant emphasis provided by the Federal and state constitutions, scrupulous care should be exercised by courts and judges to avoid rulings, on motions for the direction of a verdict, which in effect wrongfully deprive a litigant of the cherished right. On such a motion our function is not to evaluate the evidence for the purpose of determining whether fraud has been committed. I am unable to agree with the opinion of the Court because I think there was sufficient evidence to justify submitting the issue of fraud to the jury.

The opinion of the Court recognizes that the testimony of Glickman and the evidence of the gastro-intestinal examination were insufficient to sustain the direction of a verdict, and correctly states the issue thus: "The case of the Government for a directed verdict rests, therefore, upon the statements of Pence made after the reinstatement of his insurance and contradicting the representations in his application for reinstatement". So stated, the case presents a controverted question of fact, and, in view of the evidence in this case, it was for the jury to find the answer by resolving the conflict between the two contrary sets of self-serving statements made by Pence.

It is admitted that "Pence's representations in the application were not evidence of their own veracity". As an abstract matter one would suppose that Pence's later conflicting statements were likewise "not evidence of their own veracity". However, it is said that reasonable men have no choice but to admit the truth

of those later statements because they "were repeated, and usually under oath; they are in no way improbable, and are the statements of one who, himself a doctor, spoke with knowledge of the subject and bearing of his statements". These factors might be persuasive to a jury that the later statements were true, but it is quite a different thing to hold that they absoluely compel belief. On the basis of the record an equally plausible premise is that the statements in the application were the true ones. Pence was never absent from work for any appreciable period of time. The reports of his physical examinations from 1928 to his death were not altogether consistent, and any defect disclosed was evidently thought insufficient to warrant allowing any of his various claims for disability benefits, etc. His widow testified that they were "pretty close to one another", that she believed he would have told her if anything was seriously wrong with him, and that she had no knowledge of any serious ailment or consultation with a physician on his part. All this casts doubt on the truth of Pence's statements made after his application for the reinstatement of his insurance and entitled the jury to pass judgment on them.

Whether Pence was a malingerer or not, disavowing and then asserting injury and disease as a means of collecting different benefits from the Government, is not for us to decide. Suspicion that such was the case does not justify usurping the jury's function of determining, in the light of all the evidence, which of Pence's statements were true and which were false. The case was properly submitted to the jury. Its verdict, rendered on substantial evidence, should not have been set aside.

Mr. Justice BLACK and Mr. Justice DOUGLAS join in this dissent.